much as possible of the nerve trunk, and to close the canal with bone to prevent regeneration. The fact that there has been no recurrence up to the present time, three and one-half years after the last operation, shows its advantage over the other peripheral operations, and there is the possibility that the cure may be permanent.

Fracture of the Astragalus with Luxation of the Fragments.—MAUCLAIRE and PETTITEAU (*Archiv. gén. d. chir.*, 1909, iii, 575) say that these fractures do not include dislocations complicated by fracture, since the dislocation in such cases is the dominating condition, but those cases in which the fracture is the first condition to be noted, as when a displaced fragment is detected under the skin. These fractures are very rare. The displacement is due to indirect force, the traumatism inducing secondarily forced movements of the foot in which the bone is broken and the fragments displaced. When the fracture is anterior to the interosseous ligament uniting the astragalus to the os calcis, we have a fracture of the neck or a decapitation of the astragalus. In this case the posterior fragment is fixed by the ligament and retains its normal position. The anterior fragment is caught between the weight of the body above and the bones below, so that the anterior fragment is enucleated upward under the skin on the dorsum of the foot. When the fracture is posterior to the interosseous ligament, the body of the bone loses its strong attachment and is luxated. The line of fracture may be more complicated, so that there may be several fragments. In the treatment two objects are sought after—to place the foot in good position and to obtain good function. The reduction differs from that in a fracture of a long bone, in that the fragments are more or less removed from their original location and are maintained in their abnormal position by a ligamentous apparatus which is itself dislocated. In a number of the ten collected cases a non-operative reduction was attempted without success. Such a reduction may be successful rarely, but even then it cannot be maintained with the aid of compression, and vicious callus develops, interfering with the function of the tibiotarsal joint. The frequent communication with an important joint tends to defeat consolidation and to produce a concomitant arthritis. In three cases reduction was accomplished by operation, in all of which there was a transverse fracture of the neck. The joint was freely opened and the fragments coapted. The functional results appear to have been excellent. Astragalectomy has proved to be an excellent operation. With vigorous asepsis it is a benign operation, which leaves perfect functional results, except in running and jumping. In all the cases it gave good results, except in that of Frischen, which resulted fatally. This occurred previous to the period of antisepsis. A total astragalectomy is usually preferable to a partial. In a compound fracture an astragalectomy should be done as soon as possible.

The Technique of Intrathoracic Resection of the Œsophagus.—TIEGEL (*Zentrabl. f. Chir.*, 1909, xxxvi, 1009) says that the end-to-end union of the œsophagus to the stomach has certain advantages over the lateral anastomosis as recommended by Sauerbruch. It saves a valuable portion of the œsophagus which must be sacrificed for a lateral anastomosis, in which it is also difficult to place the sutures. The union is also more secure than in the latter. The method suggested by Tiegel is based upon experimental work on dogs, and makes use of a modified Murphy button. This consists in giving to the male portion of the button a more expanded bell-like shape. An obturator is made to fit into it and to catch by a spring which may be loosened by light pressure of the finger. The female portion is exactly the same as in the Murphy button. After the cardiac portion of the stomach has been completely separated from the diaphragm and the vagi nerves from the œsophagus, the œsophagus is divided by a Paquelin cautery between two clamps, about 4 cm. above the stomach. After compressing the cardiac end by a piece of gauze the clamp is removed and the female portion of the button is introduced into this portion of the œsophagus and the clamp again applied. The button is then directed into a portion of the fundus of the stomach by the finger, and is held there by a compress or a loose ligature. If there is a tumor at the cardia the button must be introduced through a small incision, which must be immediately closed by a clamp or suture. The œsophagus is ligated below the tumor, and this, with the attached piece of œsophagus, is removed by a Paquelin cautery and the edges of the cardiac opening in the stomach closed by turning in the edges with sutures. Then a movable piece of stomach is drawn into a cone with tenaculum forceps, and a purse-string suture introduced around and about 1.5 cm. from the point of the cone, including the serous and muscular coats. The ends of this suture are left loose. The oral end of the œsophagus is then turned forward by the attached clamp and a similar purse string suture placed in it, a loop being left opposite the free ends. Then a compress is placed on the œsophagus above and the end of the same cut through close to the clamp. With the aid of the ends of the purse-string suture and the loop opposite, the male portion of the button is easily introduced with the obturator. The suture is then tied around the cylinder of the button. The female portion of the button lying loose in the stomach is now forced into the cone already prepared for it, and an incision is made in the point of the cone over the button and just large enough to permit the cylinder to be forced through. The obturator is now removed from the œsophageal portion of the button and the two portions pressed together and locked. The purse-string suture in the stomach wall is drawn upward so that it may be tied above the male portion without constricting the œsophagus. This brings the serous surface of the stomach against a considerable portion of the outside surface of the œsophagus, and makes a good closure of the line of union between the œsophagus and stomach.

Cancer of the Kidney; Extirpation; Cure.—PILLET (*Ann. d. mal. d. org. gén.-urin.*, 1909, ii, 987) removed a cancerous kidney about the size of the fœtal head. The incision was made along the crest of the ilium, turning upward toward the thorax and ending in the epigastric fossa. Although extensive, this incision makes a good exposure of renal tumors. The musculocutaneous flap was turned over on the abdomen and the twelfth rib resected. The tumor was then enucleated after ligating the venous plexuses uniting the tumor to its capsule. The inferior pole of the kidney was enucleated with difficulty, the promontory being